

HIGHLY MOBILE POPULATION DRIVES THE SPREAD OF AIDS IN KENYA

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BACKGROUND

Kenya covers an area of approximately 569,000 square kilometres out of which 11,200 square kilometres are covered by inland water. Only about 20 per cent of the land is arable, the rest being classified as arid and semi-arid land.

These geographical conditions have led to a concentration of Kenya's 29 million strong population in the central and southern parts of the country where population densities average 47 people per square kilometre but reach 230 persons per square kilometre in the most densely populated areas while northern Kenya has areas averaging only three persons per square kilometre. The incidence of the AIDS epidemic relates directly to population densities with incidence of the disease found to be highest in Nyanza, the Western provinces and the Central Province. By 1997, up to 30 per cent of all Kenyans lived in urban areas where the majority do not have access to proper sanitation, and the demand caused by an average yearly growth rate of 2.6 per cent has strained services.

The *World Development Report for 1998/99* lists the Gross National Product as US \$9.3 billion (Kenya shillings 604.5 billion) with an average annual growth rate of 2.3 per cent and Gross Domestic Product of US \$9.89 million. Indicators for the quality of life are poor with child mortality resting at 90 per 1000 births. Nearly one in every four children under the age of 5 suffers from some degree of malnutrition. Life expectancy at birth is 57 years for men and 60 years for women. Adult literacy is 70 per cent for women and 86 per cent for men.

Forty per cent of the population live below the poverty line, and the situation is worse in rural areas. Distribution of income and consumption is staggered disproportionately towards the rich with the richest 10 per cent consuming 47.7 per cent while 80 per cent of the population share out 37.8 per cent among themselves. The widespread poverty in Kenya has created conditions in which people are constantly on the move in search of better living conditions and this has implications for the spread of infectious diseases including AIDS.

MOBILE POPULATION AND THE SPREAD OF AIDS IN KENYA

Even in the semi-darkness of dawn there is movement. Busia Town on Kenya's western border with Uganda is already alive with activity as people carry their wares towards the "Bus Park" open market where they hope to make a little money.

Many come from the nearby Sophia Estate while an equally large number have crossed the border from Uganda travelling early to avoid the clinging humidity that will soon trap everything. Paul Wanyama has carried beans and groundnuts from Uganda while his colleagues bring in second-hand clothes and electronics as well as grains. In the evening they will carry home salt, cooking oil and soap to sell on the other side of the border. Sitting next to him and protected from the swelling heat by a perforated sheet of polythene hung on three sticks is Michael Wegesa who makes his living exchanging Kenyan and Ugandan currency.

As the market and shops open for business, traffic flowing into the Town increases rapidly and traders are kept busy by a constant flow of enquiries. The high mobility of people in Busia is typical of busy border regions and areas to which people are attracted and brings into play unique conditions that encourage the spread of AIDS.

"When you think of a border town, there is a lot of movement in and out," says Maureen Ong'ombe of the Kenya AIDS Non-governmental Organizations Consortium, KANCO. "Border towns are a good example of possible impacts of mobility. They tend to be cosmopolitan with a mix of people interacting on different levels many of whom are only there temporarily," Ong'ombe, who works as Communication Officer for KANCO, says.

There tends to be more money in circulation, which encourages an active social life as is evident from the loud music that spills out of the numerous bars and lodgings and hotels in Busia Town. Along the main street it seems that every other shop is a bar and lodging and as early as 10 a.m. patrons are in evidence. Little information exists to link mobility directly with the spread of AIDS in the town and the surrounding Busia District, but infection rates for the District are estimated at 30 per cent of the population and are among the highest in Kenya. Nationally, the highest infection rates are found amongst working men who have money and are mobile.

Mary Makokha works with people with HIV/AIDS in Butula Division of the District and believes migratory patterns do impact on the incidence of HIV/AIDS, changing coping methods and social attitudes to sexuality. People usually leave their homes in search of better economic opportunities, some travelling only a short 10 kilometres to settle in areas where it is easier to find jobs or to trade while others travel further. In the case of Busia, Makokha says they come from both sides of the border and have intermarried and interacted to such an extent that it is difficult to define people by nationality.

In their new context, different lifestyles and coping methods emerge. Makokha, who co-ordinates the Rural Education and Economic Enhancement Programme [REEP] in Butula, Busia District, says promiscuity coupled with alcoholism is

deeply rooted. This, she says, leads to risky sexual behaviour and high HIV infection.

"In almost every house in this Division there is someone with AIDS."

Movement between rural and urban homes even within a restricted area like Busia District is now frequent and may explain the rapid increase in HIV infections. Mobility associated with migration is usually temporary; people leave their villages hoping to find seasonal or temporary work but always hope to return home. Despite moving to town, migrants tend to keep in touch with their families and friends at home, ensuring regular contact especially over weekends and holidays and an infected individual may spread HIV/AIDS to others at both ends of the chain.

Fred Majani, a counsellor with REEP, is living with HIV and he believes his experience demonstrates the reality of many people from the area. After graduating as a clinical officer he took up a posting as a district health officer in a neighbouring district. In this way he believed he would remain close enough to be home every weekend with his wife who looks after the home in Busia and still be within easy reach of his work station where he earned a living. During this period he had several relationships with women and he believes one of these resulted in his infection which he passed to his wife.

Mobility linked to urbanization has long been recognized as a factor in the spread of AIDS in Kenya but little has been done to understand the enormity of it, the vulnerability it creates and its impacts on the lives of people. Without this understanding, it is impossible to define prevention strategies which work. In 1960, only 7 per cent of all Kenyans lived in urban centres but this number has risen to 28 percent of Kenya's 29 million people and is largely attributed to economic factors [UNFPA, 1998].

The capital, Nairobi, for example, has experienced rapid growth rising from a population of 343,500 at independence in 1963. "During the last National census in 1989, the population of Nairobi was recorded to be 1,324,570 with a total male and female population of 752,597 and 571,973 respectively," says Nairobi Mayor Councilor Samuel Mbugua. The Council now estimates the popula-

tion of Nairobi to be over 3 million with a growth rate of 6%, more than half of whom live in slums. While a population growth rate of 2.6 has played a role, the urbanization process in Kenya is largely attributed to rural-urban migration. Young school-leavers in search of employment and other opportunities in the urban centres are the most dominant migrants. It is in the slums on the periphery of towns where many of those who migrate from rural areas end up. The lucky ones find employment at minimum wage while those who are not as lucky find themselves trapped in poverty without the means to travel back to their homes and restricted hope of ever leaving the slums.

Ann Njoroge works with people living with HIV/AIDS in Korogocho slums on the eastern side of Nairobi. The Eastern Deanery Aids Relief Program of the Catholic church provides medical, psychological and spiritual services and Njoroge says 68 per cent of the 4,000 people currently in the programme are single mothers with children. Most of them came to Nairobi looking for economic opportunities.

"Many of these women are alienated from their rural families for a variety of reasons," explains Njoroge who says one of the aims of the programme is to reconcile these mothers with their families. "To date we have managed to reconcile almost 170 families and this helps to put the mothers at rest by allowing them to plan for their children with their families before they die."

Alienation from rural families has reached critical proportions as Ann Owiti, coordinator of a community-based programme for AIDS orphans and their families in Kibera slums, knows too well. The Kibera Community Self-help Program (KICOSHEP) which Owiti coordinates is based in Mashimoni, one of 13 villages that constitute Kibera, the giant slum in the heart of Nairobi. Kibera is home to an estimated 850,000 people who, in common with most poor communities world-wide, have had the social and economic systems on which members of the community depend for their survival, challenged and stretched to capacity by AIDS. Ironically this comes at a time when

the government of Kenya is encouraging community-based care, based on the context of the extended family to care for people living with HIV/AIDS.

"It is important to understand that relationships in the slum are borne of need and practicality," says Owiti, explaining that those who end up in the slums usually did not plan their lives to turn out this way and most only intend to be there temporarily.

"A man working as a night watchman in the city might enter into a relationship with a woman simply to ensure that he has someone providing security for his house while he is away," says Owiti. In exchange, the woman gets food, shelter and a measure of protection for herself. It is not uncommon for men living in such arrangements in the urban centres to leave behind wives in the village.

The fact that slums are inherently unhealthy places with lack of access to running water and stinking open sewers, no electricity, no roads, high crime rates, over-crowding and limited access to health facilities only aggravates the risks. These factors also make it difficult for those planning AIDS interventions to reach populations living in these areas. The result is that Kibera, said to be the largest slum in sub-Saharan Africa, has a high incidence of HIV/AIDS estimated at 25 per cent and growing. Currently the KICOSHEP programme serves close to 700 children orphaned by AIDS but hundreds of others cannot be reached.

Attitudes towards sex have definitely changed. Achola-Ayayo (1998) conducted a study on sexual practices and risk of the spread of AIDS and found that three quarters of interviewees in urban areas no longer believe in cultural values that restricted sex before and outside marriage. This is strong evidence that social, cultural and economic changes have taken place with rapid urbanization.

With an average population growth rate of 2.6 per cent, the population of Kenya was expected to reach 50.2 million by the year 2025. Revised projections released recently, however, suggest that the AIDS epidemic could stabilize the population at 32 million in 12 years time at

which point population growth will have slowed to 0.6 per cent because of HIV/AIDS.

Busia represents a microcosm in its own right but also features significantly in the pattern of spread of the disease in Kenya. Busia is the most westerly point of the Trans-Africa Highway in Kenya. The Highway begins at Mombasa seaport and cuts a swathe inland to serve six land-locked countries. Everywhere the Highway goes the epidemic follows and the same patterns appear to hold along other significant road networks.

Towns with the highest recorded incidence of HIV/AIDS include Nakuru, Kisumu and Nairobi at 20-30 per cent, followed by Mombasa, Kakamega and Thika with a prevalence of 10-20%. (Kenya, Mulindi et. al., 1998). With the exception of Thika, all these urban areas are also major truck stops on the Highway. Thika, on the other hand, is a rapidly expanding industrial centre and has in recent years attracted droves of people from all over the country who come in search of employment.

Boom towns have grown around the truck stops with many sex workers to whom the truck drivers and their assistants may turn while away from their spouses.

Although they are not counted as migrants, long distance truck drivers are of particular concern because they are at high risk and can spread HIV/AIDS and STD's long distances. They travel frequently, often through urban areas with high levels of HIV and because they are away from home for long periods of time, they tend to have many different sex partners.

A 1994 study showed that about one half of truck drivers arriving in Rwanda from Mombasa and Nairobi, Kenya, were HIV positive. Another study of 200 adolescents who frequent truck stops in Kenya found that half the boys and one third of the girls reported having had at least one STD indicating early sexual activity and hence vulnerability to HIV and AIDS. Studies have also supported the theory that the geographic distribution of HIV and AIDS reflects a diffusion process in which major roads act as principal corridors for the spread of the virus between urban areas and other proximal

communities. One such study of truck drivers and their assistants found 1/3 to be HIV infected and there was evidence that they had travelled widely within six countries served by Mombasa Port including Kenya, Uganda, Tanzania, Zaire, Burundi, and Rwanda.

As early as the mid-80s, scientists had shown a series of epidemics among sub-populations with varying levels of risk. Data from a study led by Dr. Peter Piot showed clearly that HIV infection in Kenya spread first and most extensively to Commercial Sex Workers (CSWs). This was followed by STD clinic patients likely to include clients of CSWs and finally to the general population as evidenced by slow and then accelerating spread among pregnant women. This led to interventions that directly targeted truck drivers, CSWs and later to other groups classified as "high-risk" such as beachboys, watchmen, soldiers and prisoners, targeting the distribution and use of condoms and education on how HIV/AIDS is spread. The piece-meal targeting of high-risk populations has had some success but has not addressed the whole phenomenon of mobility, the vulnerabilities it introduces and the impact on the spread of HIV/AIDS. Part of the problem is technical.

"It is a subject that is difficult to research because of the very fact of the mobility of the people," says Maureen Ong'ombe of KANCO. The study group would be constantly changing and migration, being such a temporal phenomenon, would raise questions as to the validity of these studies. She says this is further complicated by attitudes towards the whole issue of sexuality as a private matter. "People tend to tell you what they think you want to hear and study results would not be authentic unless the researchers cultivate a long-term relationship with members of the study group."

In the case of migration, mobility is largely driven by the quest for a better economic potential. Nothing demonstrates this process as clearly as the relationship between the spread of HIV/AIDS and the military.

Prior to the establishment of a military base at Gilgil, about 120 kilometres to the west of the

capital Nairobi, there was little to draw people to this small town. Although the town rests on the trans-Africa highway, truckers and other travellers preferred to stop in Naivasha and Nakuru where tourist attractions had helped to establish thriving urban centres. Once the military barracks was set up in Gilgil things changed.

"People recognized military officers as people with money, and they set up all sorts of businesses around them," says Major Samuel Ndegwa, who is involved in HIV/AIDS programmes in the military. Commercial sex workers were among the first group attracted knowing that the military is mostly made up of salaried and unaccompanied men who would, therefore, be more vulnerable to sexual advances. The liberal availability of alcohol in the camp did not help matters.

Ndegwa says the isolation of soldiers from family and friends coupled with their high mobility are critical issues that have encouraged the spread of HIV/AIDS among this population, and national borders do not limit the movement of soldiers either. "Our soldiers have served on UN Peacekeeping missions everywhere... Yugoslavia, Jordan, Namibia, West Africa and all over Kenya" he says.

"These people have feelings and needs just like you and me. When they are taken away from their wives and girlfriends for even a whole year without a break, what can we expect?"

The links between CSWs and military officers have roots in history. Margaret Gatei of the National AIDS and STDs Control Programme (NAS COP) in the Ministry of Health recounts that the famed Pumwani sex workers are descendants of a group of military camps. These women are currently part of a study which aims to understand their apparent resistance to HIV/AIDS.

The extent of infection in the military is considered high and has led to the establishment of several HIV/AIDS prevention programmes. One of these is the Civil-Military Alliance to Combat HIV and AIDS, a regional network of military organizations which the Kenya Armed Forces are

part of. This programme aims to encourage prevention, advocacy, policy debate and programme development in military and defence forces.

PEOPLE IN CRISIS: REFUGEES AND THE INTERNALLY DISPLACED

Sessional Paper No. 4 of 1997 on AIDS in Kenya says the influx of refugees from different countries in the region has had a negative impact on the AIDS situation in Kenya. There are a number of "permanent" refugee camps in Kenya, most of them located in the North East and North West of the country. In the North East there are three camps, one near Dadaab and two others in Garissa Town. They are home to about 119,000 refugees mainly from Somalia.

In the North West is the UNHCR Kakuma Camp near Turkana housing about 51,000 refugees mainly from Sudan, Ethiopia and Somalia. There is also a camp at Lokichoggio close to Kakuma. Thousands of other refugees who have been able to obtain residency papers live and intermingle without hindrance alongside the rest of the population while others remain among the nameless, faceless unregistered population. Thousands of local and expatriate employees have moved into Lokichoggio alone to provide assistance to the refugees while many others use the town as a base for conflict resolution and development activities targeted at South Sudan.

The Sessional Paper, adopted by Parliament on 25 September 1997 to guide organizations and institutions addressing AIDS in Kenya, says: "the need to collaborate with other agencies is critical. The government will collaborate and work closely with UNHCR to mount preventive education programmes and provide health and social support to those infected with HIV". Beyond this broad statement, nothing is said of what needs to be done and who should be involved or what interventions should be put in place. To date, much of the work of rehabilitation and repatriation has been left to the United Nations through the High Commission for Refugees which has for some time recognized HIV/AIDS as a serious problem requiring a strategy.

UNHCR says the majority of HIV infections in refugee situations are sexually transmitted. "The disintegration of community and family life leads to the break-up of stable relationships and the disruption of social norms governing sexuality."

"Interaction between the refugees and local population is likely to happen and hence the need to provide service to all. Failure to do so would be counterproductive in terms of preventing the spread of STDs and HIV," says a UNHCR report. "A major lesson of the AIDS pandemic so far has been that HIV spreads faster in conditions of poverty, powerlessness and social instability – conditions that generally prevail for refugees."

Refugee populations are recognized by the Kenya government as being particularly vulnerable but there is silence on which government organs or individuals are expected to co-ordinate and follow up on recommendations as well as the means and resources. Programmes undertaken by UNHCR have understandably been preoccupied with providing refugees with the basic essentials although HIV/AIDS programmes are now part of the parcel. It is clear that greater linkage may be necessary between UNHCR and the national programme on HIV/AIDS prevention if both are to realize their goals and the mandate and the policy framework may need to be expanded to include other areas.

Related to the refugee mobility is the largely ignored plight of the internally displaced within Kenya. The international community says primary responsibility for their safety and assistance lies with their own government which has not responded adequately.

Since there is no one agency within the UN with overall responsibility for the internally displaced, a number of different UN agencies have been designated on an ad hoc basis by the UN Secretary General to administer programs for the displaced including UNHCR, UNDP and UNICEF.

Ahead of the 29 December elections held in 1997, four of the six districts in the Coast Province to the east of Kenya experienced violent raids by armed gangs operating under the umbrella of Association of Pwani Peoples who

claimed to be on a mission of ethnic cleansing. The four districts, Mombassa, Kwale, Taita Taveta and Kilifi, have a population of about 1.9 million people including a significant population of people who have migrated to the area in search of work in the lucrative hotel industry. It is these people from "up-country" who the raiders were said to be targeting.

More than 70 people were killed in the skirmishes and at least 5,000 people sought refuge in church compounds in the area while the majority of victims found shelter in the homes of relatives or friends and other safer areas of Mombassa. Many others, especially women and children, moved back inland to live with extended family and friends in their places of origin. These people are more difficult to identify but based on the original population of the affected areas the total number of people directly affected by the violence and terror may run to 100,000.

These are not the first cases of internally displaced people. An estimated 350,000 people were displaced by the ethnic conflicts of 1992-1995 which affected three of Kenya's eight provinces – Rift valley, Nyanza and Western Provinces. Many of these people have yet to return to their homes for fear of repeat attacks.

Lucy was, until 1997, a resident of Mishoromoni in Mombassa. "Before I came here (Mombassa) I used to live in Narok at a place called Maela. We were also chased away from there in 1993," she says referring to the Rift Valley clashes. "I have lived here for about 18 months and now I have to move again," she says ponderously.

Many of those displaced from the Rift Valley fled to Nakuru, the largest town in the Province, where they have started self-help groups and small development projects such as tree planting and kitchen farming as well as tailoring and carpentry. They have also started an AIDS awareness campaign after noting a shocking increase in the incidence of the epidemic among their population. Infection rates for Nakuru shot up from 10 per cent in 1990 to about 25 per cent in 1997.

Frederick Ndungu Njenga, Coordinator of Griss Self Help Group based in Molo Town, 40 kilometres west of Nakuru, says the area faced

serious socio-economic crisis following the sudden and large influx of people fleeing ethnic clashes.

"Most of those who came to Molo are young people and women without meaningful employment, technical skills or the means to generate an income," Njenga adds.

He says they have not received much in the way of assistance and they are not recognized as a "real" community and so development activities were not targeted at the community for some time. The hard circumstances forced many into sexual relationships for emotional reasons as well as for money and the number of HIV/AIDS soon began to show up among the 400 women and more than 300 youths over the age of 15. Griss, formed in 1992, has increasingly had to face the burden of addressing the spread of the epidemic within the community and with support from several other organizations, introduced home-based care and health education programmes particularly among the youth.

A similar story of violence and social disruption is told in Isiolo District, in mid-Eastern Kenya.

"They attacked my family and stole all my property, including the ugali that was cooking at the time of the attack," a victim of banditry reportedly told the development organization, MS Kenya. "They also raped my wife, daughters and even my sons. Later the same night, they attacked my neighbour just before killing another neighbour who tried to come and save the situation." "I have finally decided to shift from my house to town and all I can say is: I am a refugee in my own district."

Isiolo District covers an area of 25,605 square kilometres. It is part of what was formerly known as the Northern Frontier District, a semi-arid mass of land transforming itself to the Chalbi Desert in the north of Kenya. The district is home to about 100,000 people, most of them nomadic pastoralists representing five major ethnic groups – Borana, Meru, Turkana, Samburu and Somali Rendile.

Since colonial times, banditry has been synonymous with the lives of the people in this

area and in much of North Eastern and Eastern Provinces of the country, who were largely ignored by development efforts. Cattle rustling, which is traditionally part of the culture of many pastoral communities, has in recent years taken on a more violent character.

"They (attackers) take their time to gang rape their victims in the presence of the whole family," says a report compiled by the Kenya Human Rights Commission (KHRC) and MS Kenya. "In almost all cases, victims report the incidents to the local police station but it's only in a few cases that any action has been taken."

Khadijah Adam, an AIDS counselor at Pepo la Tumaini Jangwani, a community-based care programme for orphans and people with AIDS, says the systematic use of rape as a weapon is responsible for the spiraling incidence of AIDS in the area. Barely five years ago, Isiolo was among areas regarded as having a low incidence of AIDS with less than 1 per cent infection rate. Now it is categorized among 29 districts with "medium prevalence" falling in the 10-19 per cent range. Currently Khadijah works with seven women's groups whose members are living with AIDS and she says there are many more.

Those families displaced to urban centres by the violence find themselves without money or any assets and both children and adults may be coerced into sex for basic needs including food, shelter and security as well as for money.

"Some residents of Manta and Maili Saba suburbs have abandoned their homes and have sought refuge at Pepo la Tumaini Jangwani."

"Peter" says he abandoned his farm after being attacked four times. During the last attack he and his wife were raped and all their household items stolen.

It is clear that steps need to be taken to introduce intervention programmes designed to address the unique conditions in situations arising out of civil conflict if Kenya is to meet the stated policy of "building a national response to the epidemic". To date there have been few attempts to understand why and how civil conflict and similar complex emergencies

affect the risk of HIV/AIDS or to identify the reason why vulnerability increases in these situations.

TOURISM

Despite its decline in recent years, the tourism industry is still one of Kenya's biggest revenue earners. At its peak in 1996, Kenya attracted close to one million visitors a year earning up to US \$500 million. Tourism contributed as much as 10% of the GNP (1996). All government efforts are directed at ensuring that Kenya becomes a primary safari destination and that the number of tourists is increased. Targets are set at attracting 2 million visitors annually and to this end infrastructure including roads, provisions for air travel and all other means of transportation.

Now the government has an aggressive international marketing campaign in place and because tourism is so critical to the economy, to a large extent it determined the denial, which was the first response to the epidemic.

"There is still denial in this country. Initially it was because some people thought that talk of AIDS was sensational and would hurt the tourism industry," says Ong'ombe. She says attitudes are much more practical now but there remains an assumption that awareness among tourists should be the responsibility of their home country; other than placing condoms within easy reach, nothing is done to address the campaign towards tourists. Nowhere in national plans and policies looking at tourism is HIV or AIDS even mentioned. Although no research has been conducted locally to examine the impact of tourism on HIV/AIDS, studies from other tourist destinations around the world indicate that interaction between tourists and local populations represents high risks for those involved.

These studies indicate that tourists generally do not consider themselves to be at greater risk of infection while on holiday than at home and most tourists respond positively to HIV/AIDS prevention campaigns. Factors such as loneliness, freedom from familiar strictures and igno-

rance of AIDS and foreign customs all contribute to the increased possibility of HIV transmission, especially among young people who travel. Often they do not understand the risks posed in a foreign society. This ignorance is compounded by the ignorance and lack of understanding in the local population, and is particularly true for hotel employees and those in related service industries including commercial sex workers who often follow the tourist trail.

"When the tourist ships are reported to be docking by the media, there is an influx of CSWs to Mombassa Town," says Esther Gatua of KANCO. Currently a programme at Mukomani Clinic in Mombassa is working with CSWs to understand the problems posed by HIV/AIDS. All the sex workers in the programme are required to have a certificate which they show to all partners indicating that they have been screened for HIV and STDs within the current month. No corresponding AIDS prevention campaign exists for other workers associated with tourism.

Until he fell sick, Wafula worked for six years in a small hotel in Malindi. A strong imposing man with a hearty laugh, Wafula augmented his meagre salary by indulging the sexual fantasies of women tourists who paid him to have sex. In 1997 he was diagnosed with AIDS and though at first able to pay his medical bills, illness eventually forced him out of the job and he returned home where he died of tuberculosis in 1999.

At age 18, Christine Nyambura had just left high school and was lucky to find employment in Nakuru in one of the better-known hotels. A huge box of free condoms had been placed in front of her at her station in the reception and clients as well as co-workers often teased her about it or made suggestive remarks. Tired of dealing with the comments, Christine eventually moved the box to a less obtrusive position and forgot about it. Today, she wishes she had bothered to think about the reason why the condoms were placed there.

Christine was infected with HIV in 1996 and is saddened by the fact that she had the

means to protect herself right under her nose.

"I just didn't think that the condoms had anything to do with me," she says. All the messages she had received on HIV/AIDS sounded as though they were geared to women involved in high-risk relationships. She and her boyfriend were in a monogamous relationship and although he had relationships before that she was aware of, this was the first time she had been sexually active in a relationship. Her boyfriend who also works in tourism had been carrying the virus and had unknowingly passed the infection to her.

"I realize now that being in a new place where everyone was essentially a stranger meant that any relationship I entered into would be risky," says Christine. "It's not like when you live in a village where you know everyone and you know their behaviour. You can literally recount what they do and who they were with every day."

Christine feels health education messages need to consider the changing realities of people and advise them that risky sexual relationships are not only those in which prostitutes are involved but also those that take place in circumstances where there is any form of doubt. More emphasis should be placed on encouraging voluntary testing by everyone entering a new relationship and less emphasis should be placed on labelling people as belonging to high risk groups such as truck drivers and commercial sex workers. "We are all at risk at some time or another," Christine insists.

Despite cases like Wafula's and Christine's, little mention is made of AIDS in relation to tourism in Kenya's policy framework documents. It appears to be assumed that visitors to Kenya, most of who are from western countries and Japan, have already been sensitized to AIDS and the means of avoiding it and are therefore at low risk. R.A. Obudho, Editor of the *African Urban Quarterly* noted this presumption. "If you trace the progress of this disease, it came in from the west," he says adding that the annual introduction of three-quarters of a million visitors should not be ignored and must be part of the national strategy addressing AIDS.

"The regional impact of tourism is highly concentrated with the coastal area being by far the biggest and this in itself has implications," Dr. Sobbie Mulindi of Patient Counselling Services at the largest referral hospital, Kenyatta National Hospital, explained. In the same context, thousands of Kenyans travel abroad each year and both their information and medical needs must also be addressed.

MOBILITY AND GENDER

An interesting aspect of the mobile populations in Kenya is the distinct gender breakdown. More men than women tend to migrate to cities like Nairobi and other urban centres where they can find work, leaving women behind in the villages in the case of rural-urban migration. As can be seen from population figures for Nairobi, the societies to which people migrate as well as those left behind are distinctly polarized according to gender.

Similarly, truck drivers leave behind their wives. In the case of refugees, the bulk of those in refugee camps and the internally displaced are women and their children while men remain behind on the battlefields or seek out new means of survival. Within urban areas similar patterns are recognized and documented. Women tend to be over-represented among the urban poor and in slums, although they are often in the minority when the whole population is considered.

The polarization predictably leads to new coping mechanisms and the breakdown of social norms, especially those governing sexuality, and results in increased vulnerability to risky sexual behaviour and HIV/AIDS. In addition to social trends brought on by human mobility, there are also important changes in the structure of families with an increasing number of homes where women are the head of the family. A significant number of women (24.2 per cent) never marry but do have children, according to studies conducted by the United Nations. Most of these women concentrate in urban areas where such norms are considered acceptable rather than in rural

areas that still tend to frown on single-mothers. They often have different sexual partners over the years.

CONCLUSION

To date, efforts in Kenya to control the spread of HIV/AIDS have concentrated on health education and awareness creation about the disease based on the knowledge that it tends to spread fastest among people who engage in risky behaviour. Almost the whole population has been reached with information on AIDS and studies have shown that knowledge about the disease is widespread. However, this has not encouraged people to change their behaviour.

“Despite having information at hand, people continue to put themselves at risk on a daily basis,” says Dr. Mulindi. “Since the inception of the National AIDS Control Programme in the late 1980s, there has been a presumptive belief that traditional health education about HIV/AIDS would be sufficient to induce widespread behaviour change. This has not proved to be the case.”

Clearly there are more powerful factors that continue to influence the choices that people make, even in life-threatening situations as those posed by the risk of being infected with HIV/AIDS.

Human mobility has contributed both positively and negatively to the creation of Kenya as it exists today. The increasing movement of individuals and large populations of people within and outside the country is part of the structure of modern Kenya and cannot be stopped. The strategic geographical position of the country with access to natural harbours; its natural resource base; its reputation as an economic centre for Eastern Africa and the relative peace that it has enjoyed in a region known for conflict, have all contributed to its attraction as a destination within the region and abroad.

The semi-arid and arid nature of the land to the north has seen development efforts concentrated along a central band and it is within this band that agriculture, industry and social

amenities are best developed and climatic conditions favour human habitation. As a result, local populations tend to migrate in search of opportunity, trade and communication with neighbouring countries within the same region. Millions of people are on the move around Kenya each year. Their reasons for moving and their circumstances differ widely. But they all face the same problems of dislocation, the need to adapt to new, often different and even difficult surroundings, even if for brief periods of time, the lack of social support structures at their destination, compromised employee rights, unexpectedly harsh economic realities and the absence of family members.

Efforts to stop the spread of HIV/AIDS must begin by recognizing this high mobility of people as a point of intervention and focus specifically on reaching people on the move with programmes that address their real vulnerabilities. This must not be done in a piecemeal manner as has been the case in the past, where certain groups such as CSWs are targeted as high risk, while others like tourists are ignored in the assumption that they have been catered for elsewhere.

The single most important challenge that Kenya has faced in her post-independence history is the HIV/AIDS epidemic. The National AIDS/STD Control programme has reported over 77,000 cumulative cases of AIDS since 1984 and an estimated number of 1.7 million people infected with HIV. The latest situation analysis of HIV/AIDS in Kenya says the epidemic has yet to stabilize and HIV infection rates have increased nationally from 3.1 per cent to 9 per cent in the past seven years. The epidemic remains powerful and dynamic. It is evolving with changing and unpredictable patterns, but a key factor that appears common to all areas where the epidemic explodes is the movement of people.

HIV/AIDS intervention programmes must look at the issue of mobility with greater thoroughness beginning with research to scientifically define the common conditions that encourage exposure to HIV/AIDS and thus influence the impact and spread of HIV/AIDS

in Kenya. Using these research findings, it will then be possible to design appropriate interventions that really reach people wherever they are. This will require greater linkage in addressing a problem of such scope and with so many facets. NGOs and international organizations need to encourage greater levels of coordination in their research and in the development of subsequent prevention programmes. The private sector must be brought in. Efforts to engage employers in prevention programmes need to be expanded to address the needs of employees; the need to be able to support a family on the salary provided, needs for proper housing arrangements for employees or regular leave to enable them to visit partners.

All government ministries and departments must be involved in tackling the underlying insecurities caused by mobility and migration and HIV/AIDS on the whole. Mobility precedes the many vulnerabilities that lead to susceptibility to risky behaviour and has numerous causes. Similarly, it demands solutions that are developed from a multiplicity of fronts as it affects every department touching tourism; trade; regional cooperation; immigration; peace and security, gender; industry, transport and communications; planning and national development as a whole -

not just health under which all responsibility for HIV/AIDS programmes is traditionally heaped.

In addressing the trans-border spread of HIV/AIDS, Kenya must go beyond isolated interventions to develop broader programmes in partnership with neighbouring countries which are equally affected by the same phenomena because mobility knows no borders. Failure to contain and control the spread of HIV/AIDS now will demand more expensive and difficult interventions later.

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